State of California
Department of Industrial Relations
Division of Workers' Compensation

OBJECTION TO TREATING PHYSICIAN'S RECOMMENDATION FOR SPINAL SURGERY

EMPLOYEE

Last Name	First Name	Other names/initials	Social Security Number	Date of Injury

W.C.A.B. Case No.

RESIDENCE ADDRESS: Street	City	State	Zip Code

EMPLOYER

Name

MAILING ADDRESS: Street	City	State	Zip Code

Insurance Carrier:

Claims Administrator:

Company providing utilization review:

Employer health care provider:

EMPLOYEE'S ATTORNEY

Name

MAILING ADDRESS: Street	City	State	Zip Code

Telephone:	Fax Number:

TREATING PHYSICIAN

Last Name:	First Name:	Other names/initials:

MAILING ADDRESS: Street	City	State	Zip Code

Telephone:	Fax Number:	E-mail:

Physician's Medical Group:

Independent Practice Association:

Exact procedure which is being objected to:

Name of facility or institution at which the proposed procedure is to be performed:

Name of facility or institution at which an alternative procedure (if any) recommended by the employer, employer health care provider, carrier, or administrator is proposed to be performed:

Date that the treating physician's recommendation for this procedure was first received by any of employer, insurance carrier, administrator:

Name of entity which received it on that date:

Type of entity (employer, insurance carrier, or administrator):

NAME OF PERSON SIGNING THIS OBJECTION:

Name:	Company:		
MAILING ADDRESS: Street	City	State	Zip Code
Telephone:	Fax Number:	E-mail:	

Reason(s) for this objection, specific to this employee:

I declare under penalty of perjury of the laws of the State of California on (date)_____,
that the enclosed physician's report was first received by the employer, insurance carrier or administrator
on (date)_____, and that on (date)_____,
I served the enclosed objection on:

(name of person served)	(means of service: e.g. mail/certified mail/fax/FedEx)	(time, if by fax)
ADMINISTRATIVE DIRECTOR		

_____
(Signature)

The declaration and this form must be signed by a Principal or Employee of the employer, insurance carrier, or administrator.

This form, together with the report of the treating physician containing the recommendation for treatment which is objected to, is to be mailed to the Administrative Director, Medical Unit, P.O. Box 8888, San Francisco, CA 94128-8888, and copies served by mail or other rapid means of delivery (such as fax or overnight delivery) on the employee, employee's attorney, and treating physician. This Objection is to be sent within ten (10) days of the first receipt by any of the employer, insurance carrier, or administrator, of the treating physician's report containing the recommendation.